

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038501

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 3031

FILED OCT 10 1963

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Clayton</b>                         |  | c. CITY OR TOWN <b>University City</b>   |  |
| Length of stay in lb Days   |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Louis County Hosp</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>1123 Parkedge East</b>   |  |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                           |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |  |

|   |                                  |   |  |                                     |                                    |
|---|----------------------------------|---|--|-------------------------------------|------------------------------------|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Mary Susan Van Loon</b>                          |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 30 1963</b>   |                                     |                                    |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-5-1886</b>  | 9. AGE (last birthday)<br><b>77</b> | 10. IF UNDER 1 YEAR<br>Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |                                     |                                    |
| 11. BIRTHPLACE (City and state or country)<br><b>Crocker, Mo.</b>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |                                     |                                    |
| 13a. FATHER'S NAME<br><b>Vernon T. Mosher</b>   |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Nancy Crumley</b>  |                                     |                                    |
| 14. NAME OF HUSBAND OR WIFE<br><b>William H. Van Loon</b>   |                                  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                     |                                    |
| 16. SOCIAL SECURITY NO.<br><b>[REDACTED]</b>  |                                  |   | 17. INFORMANT<br>Address<br><b>Norma E. Lefmann, 1123 Parkedge E.</b>  |                                     |                                    |

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| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 MIN</b> |
| DUE TO (b) <b>arteriosclerotic heart disease</b>   |  | <b>4-5 yrs.</b>                                   |
| DUE TO (c)   |  |   |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Parkinsons Disease</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|--|--|---|

|   |   |  |
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| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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|--|--|--|--|
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE |
|--|--|--|--|

|   |  |
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| 21. I attended the deceased from <b>Feb 1962</b> to <b>9/30/63</b> and last saw her alive on <b>9/18/63</b><br>Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. |  |
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|  |   |                                    |
|--|---|------------------------------------|
| 22a. SIGNATURE<br><b>[Signature]</b> (Degree or title) | 22b. ADDRESS<br><b>135 W Adams, Kirkwood Mo</b> | 22c. DATE SIGNED<br><b>10/1/63</b> |
|--|---|------------------------------------|

|   |                               |   |  |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>10-3-1963</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bellefontaine Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Missouri</b> |
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|   |  |   |
|---|--|---|
| 24. FUNERAL DIRECTOR<br><b>Lupton Chapel, 7233 Delmar Blv'd</b> | 25. DATE RECD. BY LOCAL REG.<br><b>10-1-63</b> | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |
|---|--|---|

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300  
Rev. 4/59

1 4002

2 4006

3

4 1

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12 45-0

13

AN East Scheele 90-5/201  
135 West Adams  
Kirkwood  
TUE only  
12:30 to 5 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

Clarence A. Murray

Licensed Embalmer No. ~~4011~~ 4011

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.